Advanced Beneficiary Notice of Non Coverage and Signature Requirements

Presented by:

Medicare Part B Provider Outreach and Education (POE)

May 2014

Workshop Protocol

- WebEx Registration cannot be completed using mobile device
  - Must use desktop or laptop
- Entering workshop
  - Attendee lines are muted upon entry
  - Enter additional attendee names, provider, city in Chat (not Q&A)
  - **Adobe PDF slides emailed to all registered providers**
- Throughout workshop
  - Questions pertinent to workshop slide addressed
  - Address Q & A to “all panelists”; not to host directly
  - All other questions, call Part B Provider Contact Center
- Workshop conclusion
  - Asking questions aloud? Use “raise/lower hand” feature
  - MUTE phones – never place on HOLD

CEU Process

- Attend entire workshop
- Must take short polling survey
  - **After** closing out of workshop
- CEU certificate emailed after workshop
  - No later than 5 days after presentation
  - No password needed
  - All providers may use CEU certificate
    - Certificate of Attendance no longer available

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ACRONYM	DESCRIPTION
ABN	Advance Beneficiary Notice of Non Coverage
LCD	Local Coverage Determination
MLN	Medicare Learning Network
NCD	National Coverage Determinations
CCI	Correct Coding Initiative
CERT	Comprehensive Error Rate Testing
CR	Change Request
IOM	Internet Only Manual

Agenda

- ABN form
  - Completion requirements
  - Uses
- Modifier usage
- National and Local Coverage Determinations
- Signature Requirements

Advance

(before the item or service is provided)

Beneficiary

(issued to the beneficiary or representative)

Notice of Noncoverage

(written notification that Medicare may not or won’t pay for an item or service)

noridian
Healthcare Solutions

ABN Completion

Who Uses ABN?

- Medicare Fee-For Service Providers, Practitioners, Suppliers, Laboratories and Home Health Agencies in 2013
- Given to original Medicare (fee-for-service) beneficiaries
- Notifies the beneficiary that Medicare may not allow for an item or service
- Maybe a mandatory or voluntary notice

Medical Necessity

- Medical necessity is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare Program.

ABN Information

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

ABN Information

G. OPTIONS: Check only one box. We cannot choose a box for you.

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H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

ABN Requirements

- Use Form CMS-R-131
- Issue ABN each time
- Before item/service rendered
- www.cms.hhs.gov/bni

ABN Requirements

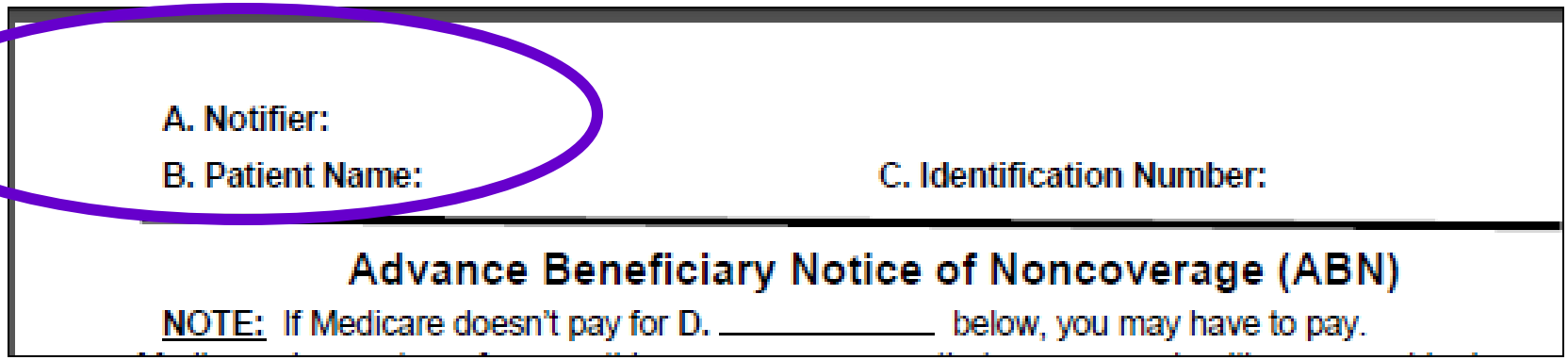
- Identify item/service
- Denial expected
- State reason for denial
- Only one page
- Type or handwrite
- 12 pt Font
- Black or blue ink

ABN Delivery

- Hand deliver
- Must be able to comprehend
- Don’t deliver under duress
- Give copy

User Customizable Sections

- Header = Notifier
  - Typed, handwritten, pre-printed, label
  - Provider Information


A. Notifier:

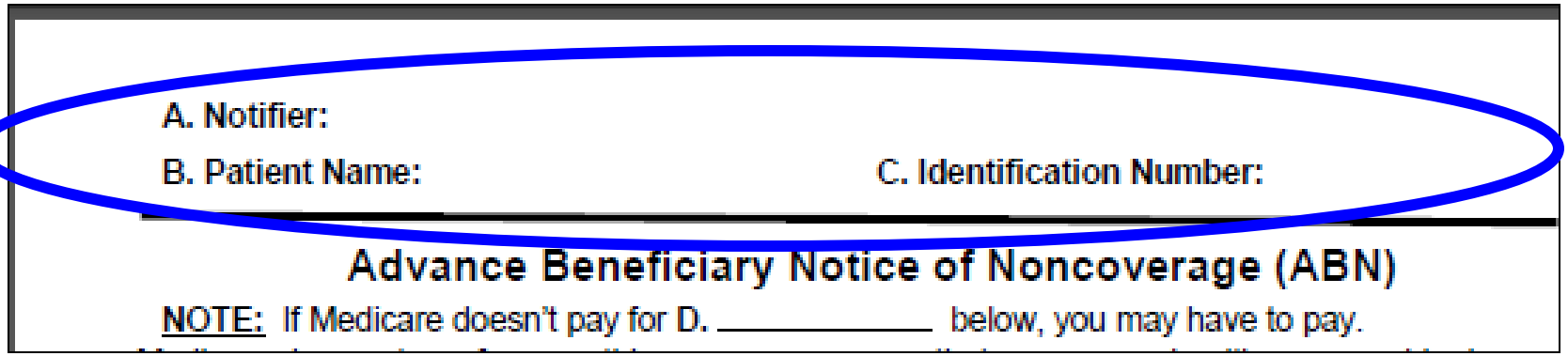
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

User Customizable Sections

- (B) Enter patient's name
- Patient ID # (optional)
  - Never use SS# or HIC#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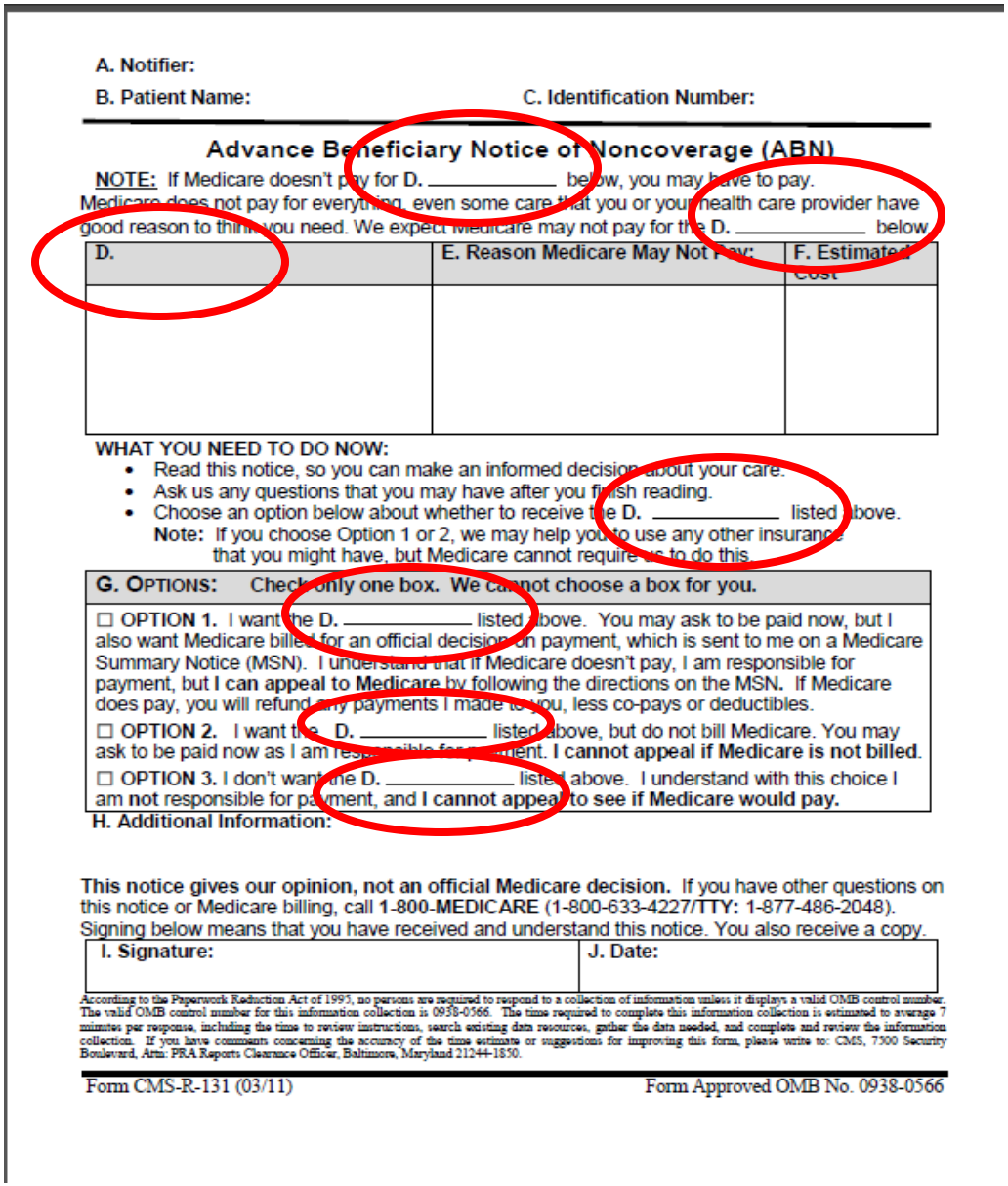

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D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

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Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Item D Complete the blanks

Enter exact service(s) that patient understands

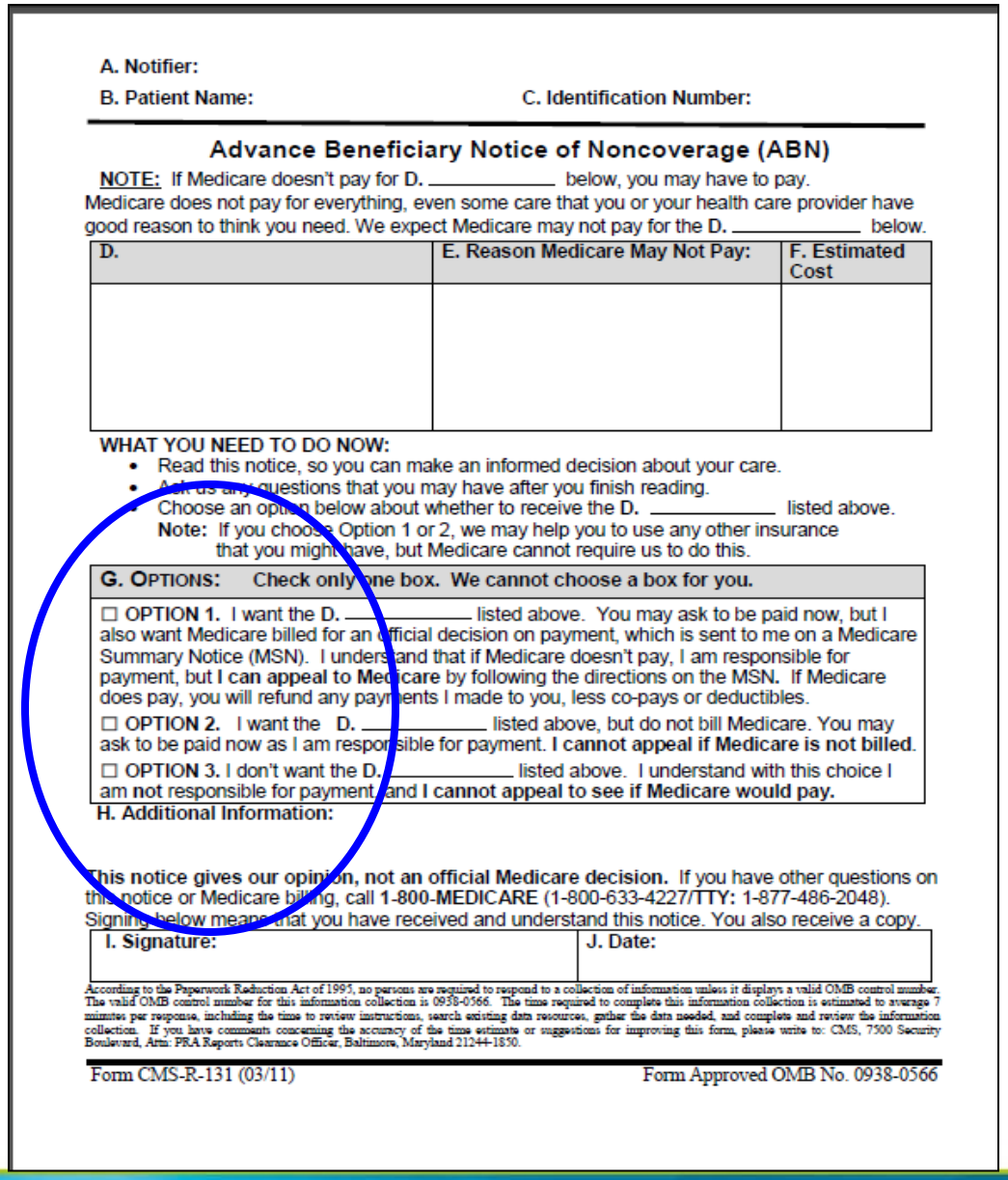
User Customizable Sections

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Item/service	Reason for denial	Estimated cost

Medicare does not pay for the (*item or service*)…

- for your condition
- more often than “_____”
- which it considers to be experimental or for research use
- because it is an excluded service from the program



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Beneficiary completes

Option 1, 2 or 3

Option 1

- Want service
- Bill Medicare for decision
  - Medical Necessity denial anticipated
- Pay now or later
- Appeals available

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Option 2

- Want service
- Don’t bill Medicare
  - Excluded services
- Pay now
- No Appeals rights

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Option 3

- Do not want service
- No bills to Medicare
- No financial liability

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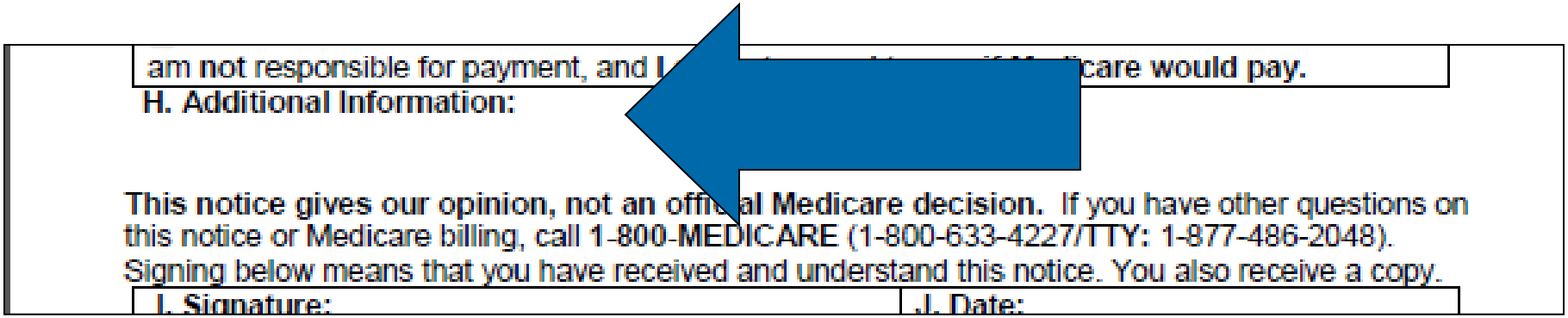
Item H

- Clarification
- Additional information
  - Translations
- 1 (800) MEDICARE


am not responsible for payment, and I
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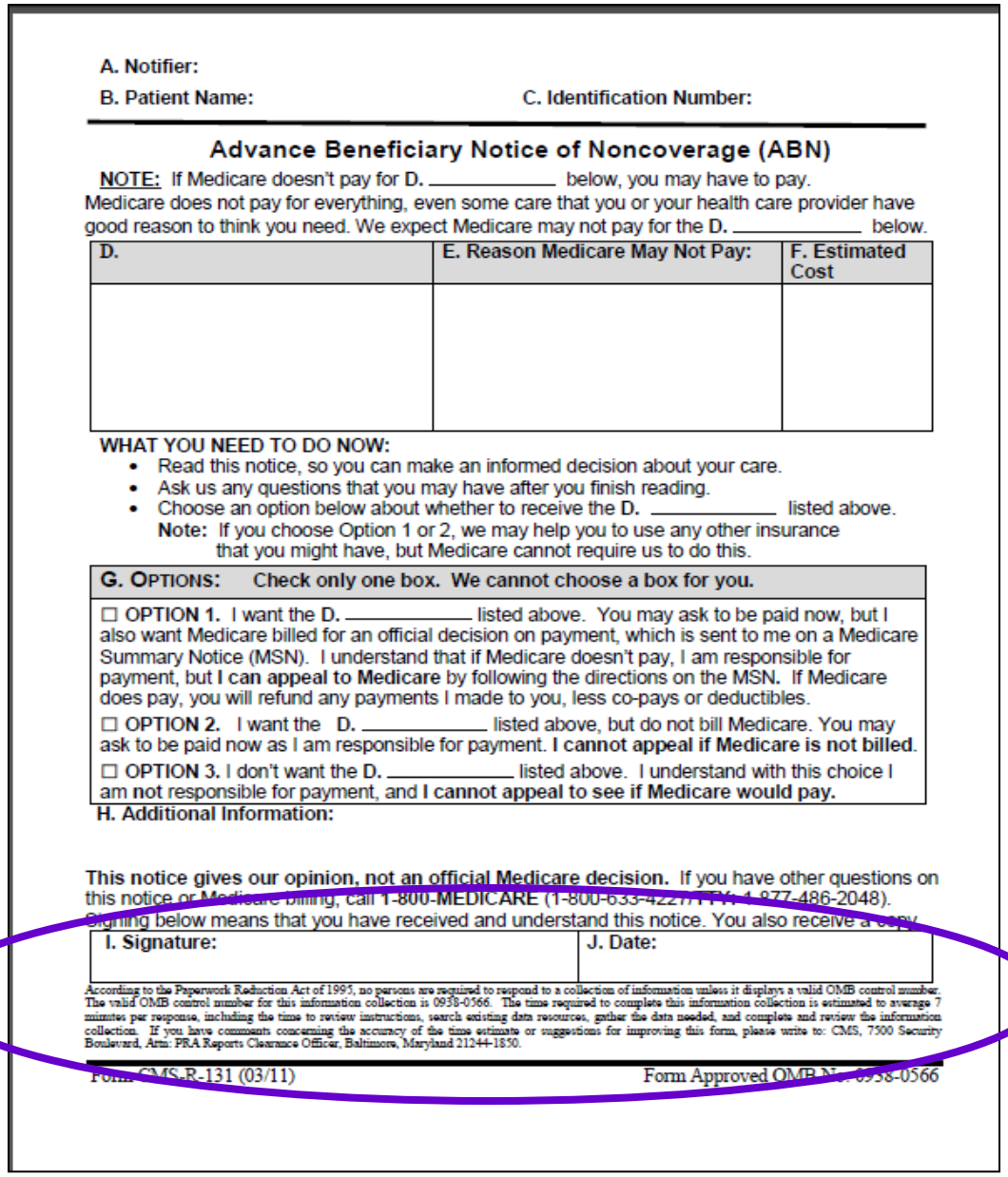

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Beneficiary completes

Item H, I and J

- Date
- Signature

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Authorized Representative

- Acting on beneficiary's behalf
- No conflict of interest
- Person indicated by beneficiary
- Disinterested 3rd party

Authorized Representative

- Legal authorization

- Beneficiary's best interest at heart
  - A spouse
  - A parent
  - An adult child
  - An adult sibling
  - A close friend

Beneficiary Refuses to Sign

- Beneficiary cannot refuse to sign ABN and still demand service/item
- If beneficiary refuses to sign, but chooses to have procedure and provider agrees
  - Document “beneficiary refusal to sign” in patient chart
  - Attesting to witnessing provision and refusal
  - Notifier and office witness both sign ABN annotation
- IOM Publication 100-04, Chapter 30, Section 40.3.4.6

Electronic Issuance of the ABN

- Patient must be given the option of paper
- Signature may be capture electronically
- Patient must be given a paper signed copy

Repetitive Services

- Patient signs original with complete information
  - Time frame covered by ABN
  - Only if no changes
- IOM Publication 100-04, Chapter 30, 50.14.3

Repetitive Services

- Patient may sign/date reverse side every visit
  - Not a CMS requirement
  - Medicare doesn't take a stand either way
- Valid up to one year
- If new triggering event with changes, need new ABN

ABN Retention

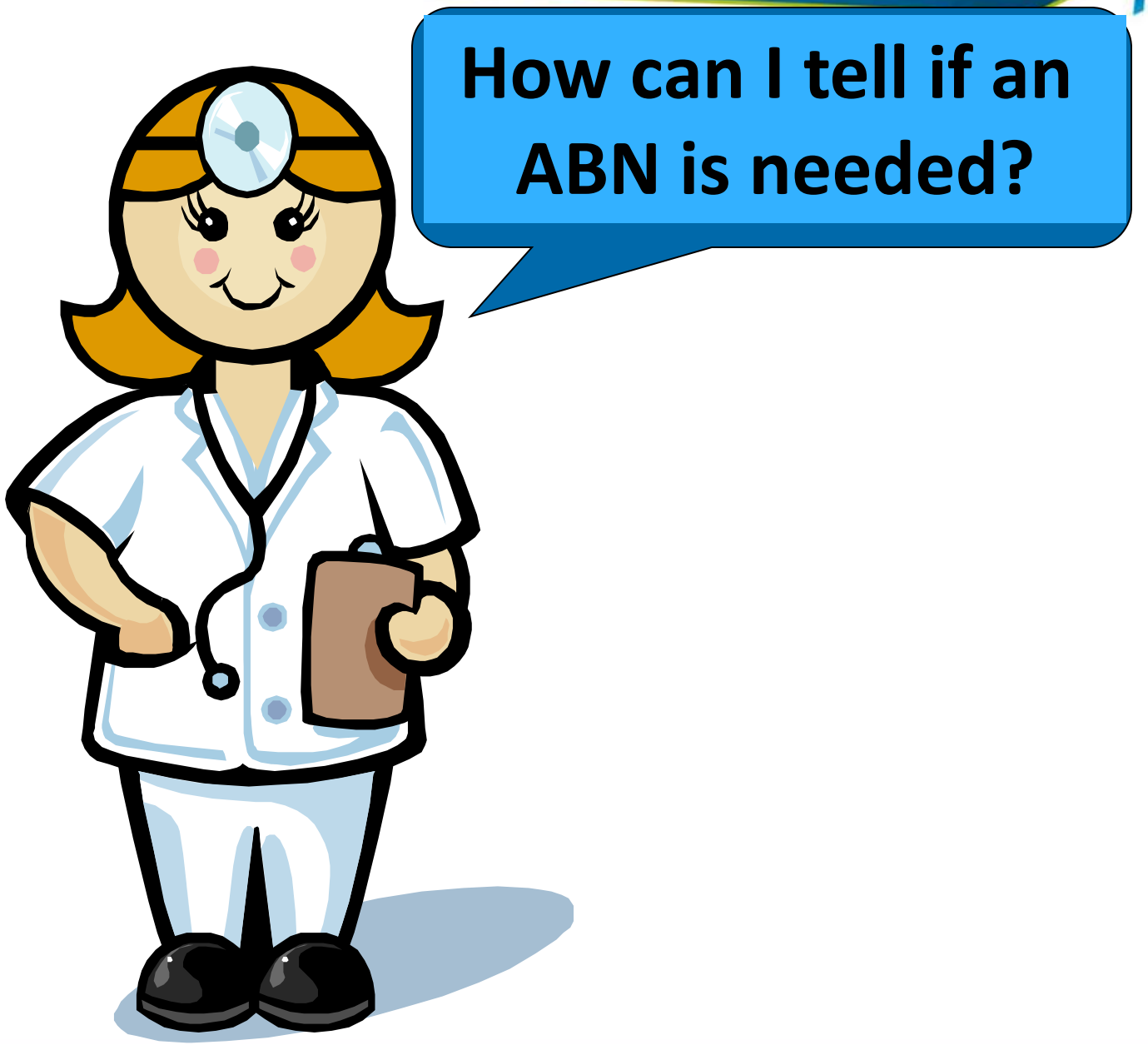
- Five years from service
  - Unless State requires longer retention
- Required to keep ABN
  - Beneficiary declined care
  - Refused to choose an option
  - Refused to sign notice

Beneficiary's Financial Liability

- Can collect usual and customary charge
  - Both assigned/non-assigned claims
  - Not limited to Medicare allowed amounts
- Return funds if provider liable
- Return funds is subsequently paid
- IOM 100-4 Chapter 30, §50.13

Financial Responsibility

- Cannot issue ABN
  - To shift financial liability to patient when full payment is made through bundled payments
    - E.g. National Correct Coding Initiative (NCCI)
  - When patient would not be financially liable for payments, because Medicare made full payment


How can I tell if an ABN is needed?

Categorical Exclusions

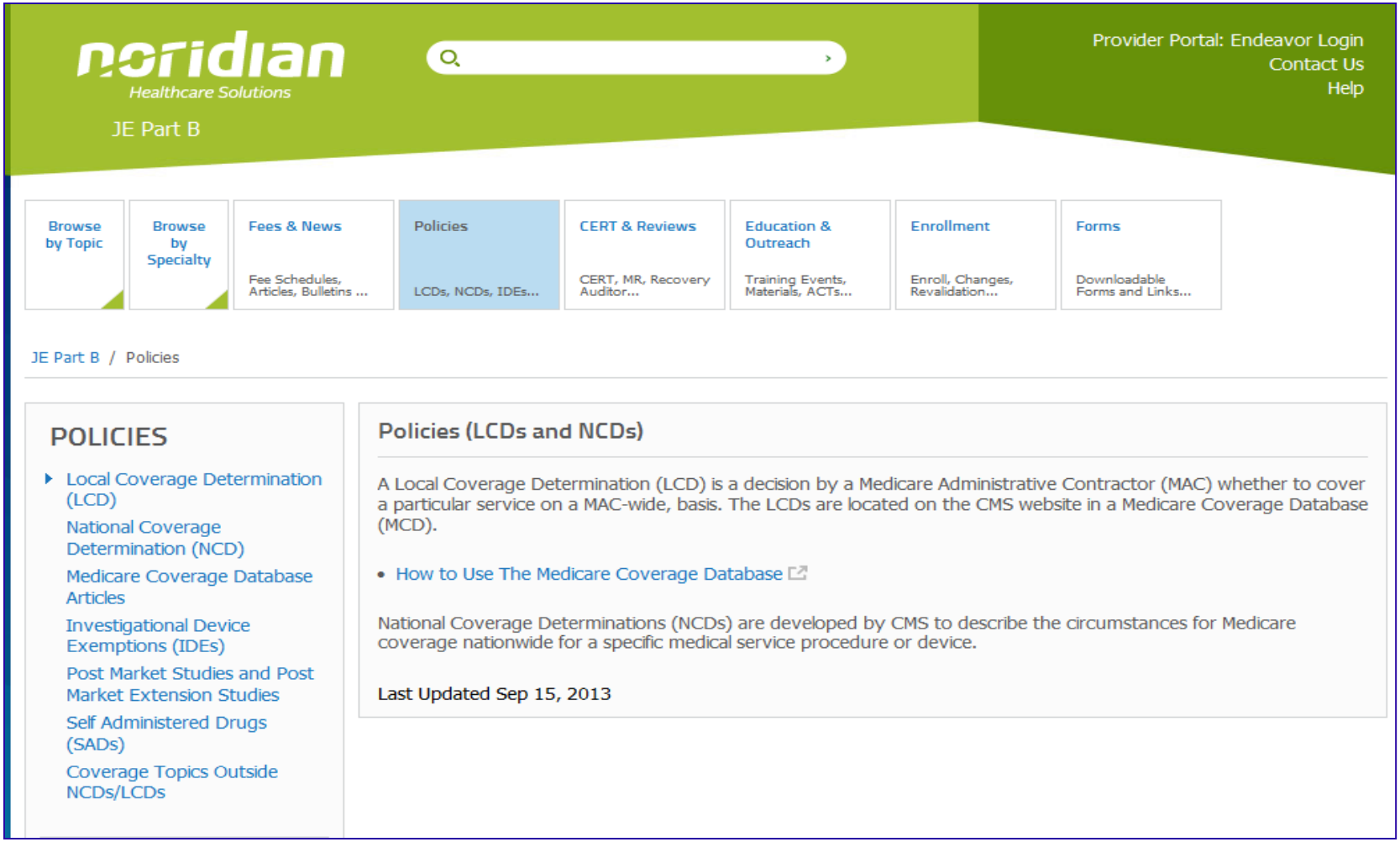
- IOM 100-4 Chapter 30 §20.1.1
  - Routine physicals & some screening tests
  - Most shots (vaccinations)
  - Routine eye care
  - Hearing aids and exams
  - Cosmetic surgery
  - Dental care and dentures
  - Orthopedic shoes and foot supports
  - Services by immediate relatives

Local and National Coverage Determinations (LCDs) & (NCDs)

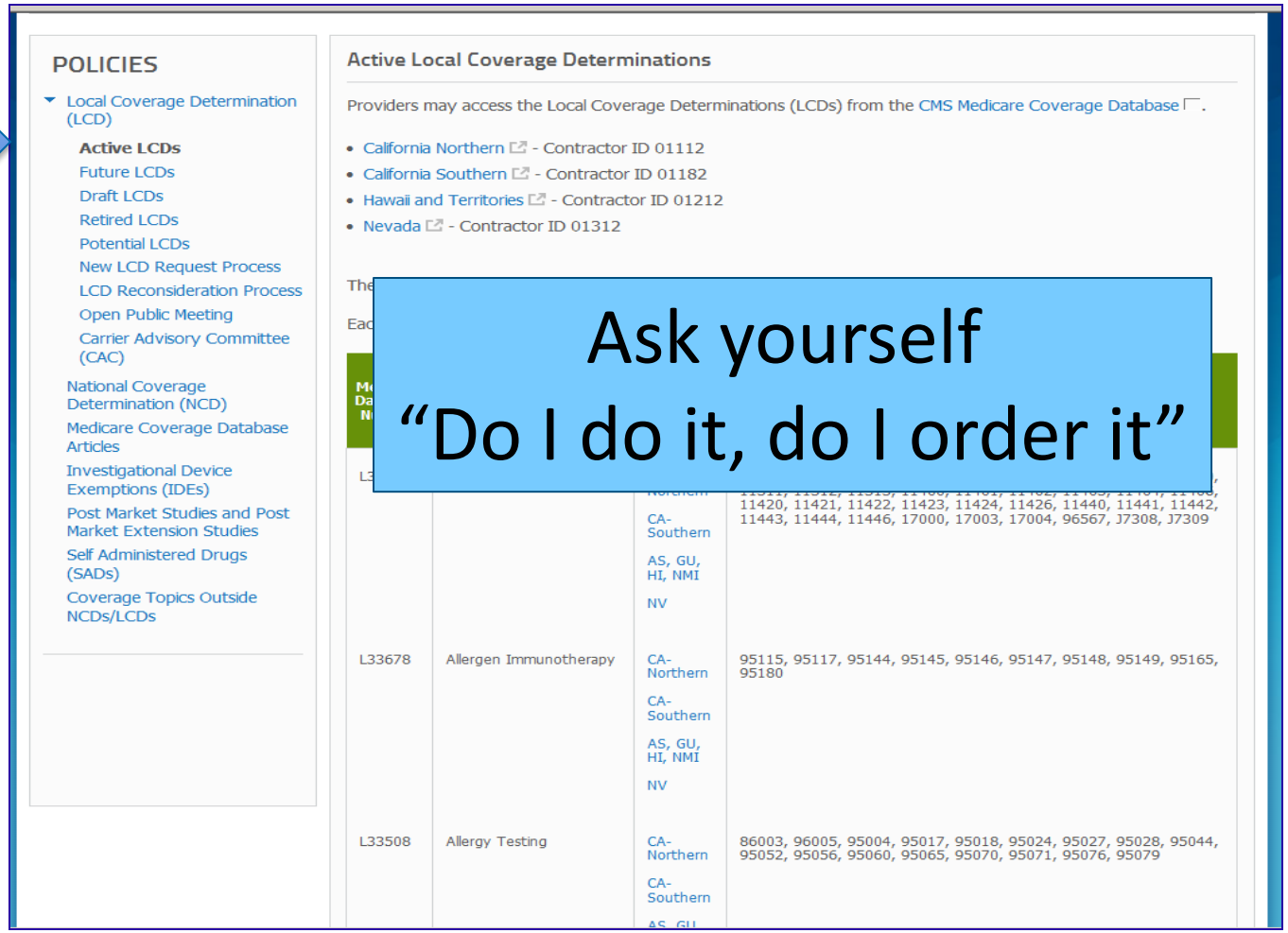
Local Coverage Determinations

- Contractor developed
- Outline coverage criteria

Policies


noridian
Healthcare Solutions
JE Part B
Provider Portal: Endeavor Login
Contact Us
Help
Browse by Topic
Browse by Specialty
Fees & News
Fee Schedules, Articles, Bulletins ...
Policies
LCDs, NCDs, IDEs...
CERT & Reviews
CERT, MR, Recovery Auditor...
Education & Outreach
Training Events, Materials, ACTs...
Enrollment
Enroll, Changes, Revalidation...
Forms
Downloadable Forms and Links...
JE Part B / Policies
POLICIES
Local Coverage Determination (LCD)
National Coverage Determination (NCD)
Medicare Coverage Database Articles
Investigational Device Exemptions (IDEs)
Post Market Studies and Post Market Extension Studies
Self Administered Drugs (SADs)
Coverage Topics Outside NCDs/LCDs
Policies (LCDs and NCDs)
A Local Coverage Determination (LCD) is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide, basis. The LCDs are located on the CMS website in a Medicare Coverage Database (MCD).
How to Use The Medicare Coverage Database
National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device.
Last Updated Sep 15, 2013

Select “Active LCDs”


POLICIES
Local Coverage Determination (LCD)
Active LCDs
Future LCDs
Draft LCDs
Retired LCDs
Potential LCDs
New LCD Request Process
LCD Reconsideration Process
Open Public Meeting
Carrier Advisory Committee (CAC)
National Coverage Determination (NCD)
Medicare Coverage Database Articles
Investigational Device Exemptions (IDEs)
Post Market Studies and Post Market Extension Studies
Self Administered Drugs (SADs)
Coverage Topics Outside NCDs/LCDs
Active Local Coverage Determinations
Providers may access the Local Coverage Determinations (LCDs) from the CMS Medicare Coverage Database.
California Northern - Contractor ID 01112
California Southern - Contractor ID 01182
Hawaii and Territories - Contractor ID 01212
Nevada - Contractor ID 01312
Ask yourself
“Do I do it, do I order it”
CA-Southern
AS, GU, HI, NMI
NV
11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 17000, 17003, 17004, 96567, J7308, J7309
L33678
Allergen Immunotherapy
CA-Northern
CA-Southern
AS, GU, HI, NMI
NV
95115, 95117, 95144, 95145, 95146, 95147, 95148, 95149, 95165, 95180
L33508
Allergy Testing
CA-Northern
CA-Southern
86003, 96005, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95076, 95079

LCD Opening Page

Coverage, Indications and Limitations

CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment only for those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1862(a)(13)(A)(B)(C) of the Act excludes payment for the treatment of flat foot conditions, the treatment of subluxation of the foot, and routine foot care.

42 Code of Federal Register §411.15(11)(I)(i), Particular services excluded from coverage concerning foot care.

CMS On-Line Manual, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16, §30, states that some foot care is covered and some is excluded.

CMS On-Line Manual, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, §290, clarifies which foot care services are covered and which are excluded from coverage.

CMS On-Line Manual, Pub. 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1, §70.2. Consultation services rendered by a podiatrist in a skilled nursing facility are covered if the services are reasonable and necessary and do not come within any of the specific statutory exclusions.

CMS On-Line Manual, Pub. 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 1, §70.2.1. Addresses services provided for the diagnosis and treatment of diabetic sensory neuropathy with loss of protective sensation (LOPS).

CMS On-Line Manual, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.4.1.3, Diagnosis Code Requirements

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For Medicare purposes, an "ulcer" does not exist until there is a partial thickness skin loss involving epidermis with or without dermis. Some authors will define a "pre-ulcer" condition and others even a "Stage 1 Ulcer" (e.g. "Wagner 1") where the skin is still intact. Such changes do not constitute an "ulcer" for Medicare payment purposes under this policy.

Ulcers may develop because of a combination of ischemia, infection, abscess, trauma, prolonged pressure, repetitive stress, edema, and loss of sensation. Their management includes:
1. Overall medical and surgical treatment of the cause.
2. Meticulous care of the ulcerated skin and other associated soft tissue with application of medications and dressings, and
3. When reasonable and necessary, debridement of the necrotic and devitalized tissue.

The management of a **symptomatic** hyperkeratosis may involve medical treatment, paring or cutting, shaving, excision, or destruction. This policy addresses only the paring or cutting approach. The other approaches are addressed in the Noridian Skin Lesion (Non-melanoma)Removal LCD.

This policy does not address treatment of burns or debridement of nails. For treatment of burns, including debridement, refer to the CPT 16000 series. For debridement of nails, refer to CPT codes 11720 and 11721.

When the only service provided is the non-surgical cleansing of the ulcer site with or without the application of a surgical dressing, the provider should bill this service with the appropriate evaluation and management (E/M) code and not a debridement code(s).

CPT codes 11042-11044 describe debridement of relatively localized areas with or without their contiguous underlying structures. These codes are appropriate for treatment of skin ulcers, circumscribed dermal infections, conditions affecting contiguous deeper structures, and debridement of ground-in dirt such as from road

List of CPT/HCPCS Affected by the Policy

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999	Not Applicable

CPT/HCPCS Codes

Group 1 Paragraph: N/A

Group 1 Codes:

10060	Drainage of skin abscess
10061	Drainage of skin abscess
11042	Deb subq tissue 20 sq cm/<
11043	Deb musc/fascia 20 sq cm/<
11044	Deb bone 20 sq cm/<
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11055	Trim skin lesion
11056	Trim skin lesions 2 to 4
11057	Trim skin lesions over 4

ICD-9 Codes that Support Medical Necessity

ICD-9 Codes that Support Medical Necessity

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: These are the **only** covered ICD-9-CM codes that support medical necessity:

Note: Diagnostic restrictions do not apply to CPT codes 10060 and 10061.

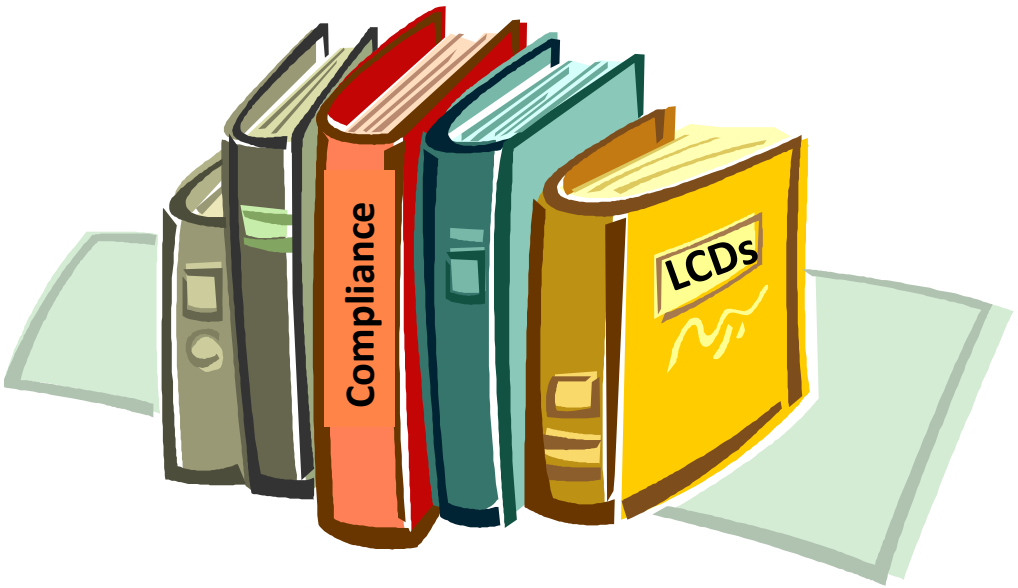
For CPT codes 11042-11047, the claim must have at least one of the following diagnosis codes:

Group 1 Codes:

249.80*	SECONDARY DIABETES MELLITUS WITH OTHER SPECIFIED MANIFESTATIONS, NOT STATED AS UNCONTROLLED, OR UNSPECIFIED
249.81*	SECONDARY DIABETES MELLITUS WITH OTHER SPECIFIED MANIFESTATIONS, UNCONTROLLED
250.80*	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.81*	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], NOT STATED AS UNCONTROLLED
250.82*	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED
250.83*	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE I [JUVENILE TYPE], UNCONTROLLED
440.23	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
440.24	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE
454.0	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER
454.2	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
459.33	CHRONIC VENOUS HYPERTENSION WITH ULCER AND INFLAMMATION
681.10	UNSPECIFIED CELLULITIS AND ABSCESS OF TOE
681.11	ONYCHIA AND PARONYCHIA OF TOE
682.7	CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES
686.8	OTHER SPECIFIED LOCAL INFECTIONS OF SKIN AND SUBCUTANEOUS TISSUE
686.9	UNSPECIFIED LOCAL INFECTION OF SKIN AND SUBCUTANEOUS TISSUE
707.00	PRESSURE ULCER, UNSPECIFIED SITE
707.01	PRESSURE ULCER, ELBOW
707.02	PRESSURE ULCER, UPPER BACK
707.03	PRESSURE ULCER, LOWER BACK
707.04	PRESSURE ULCER, HIP
707.05	PRESSURE ULCER, BUTTOCK
707.06	PRESSURE ULCER, ANKLE
707.07	PRESSURE ULCER, HEEL
707.09	PRESSURE ULCER, OTHER SITE
707.10	UNSPECIFIED ULCER OF LOWER LIMB
707.11	ULCER OF THIGH
707.12	ULCER OF CALF

Make NCDs & LCD's Accessible

- Organize NCDs & LCDs
- Educate staff



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National Coverage Determinations (NCDs)

National Coverage Determinations

- CMS developed
- Outline coverage criteria
- http://www.cms.hhs.gov/mcd/indexes.asp?clickon=index

http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html

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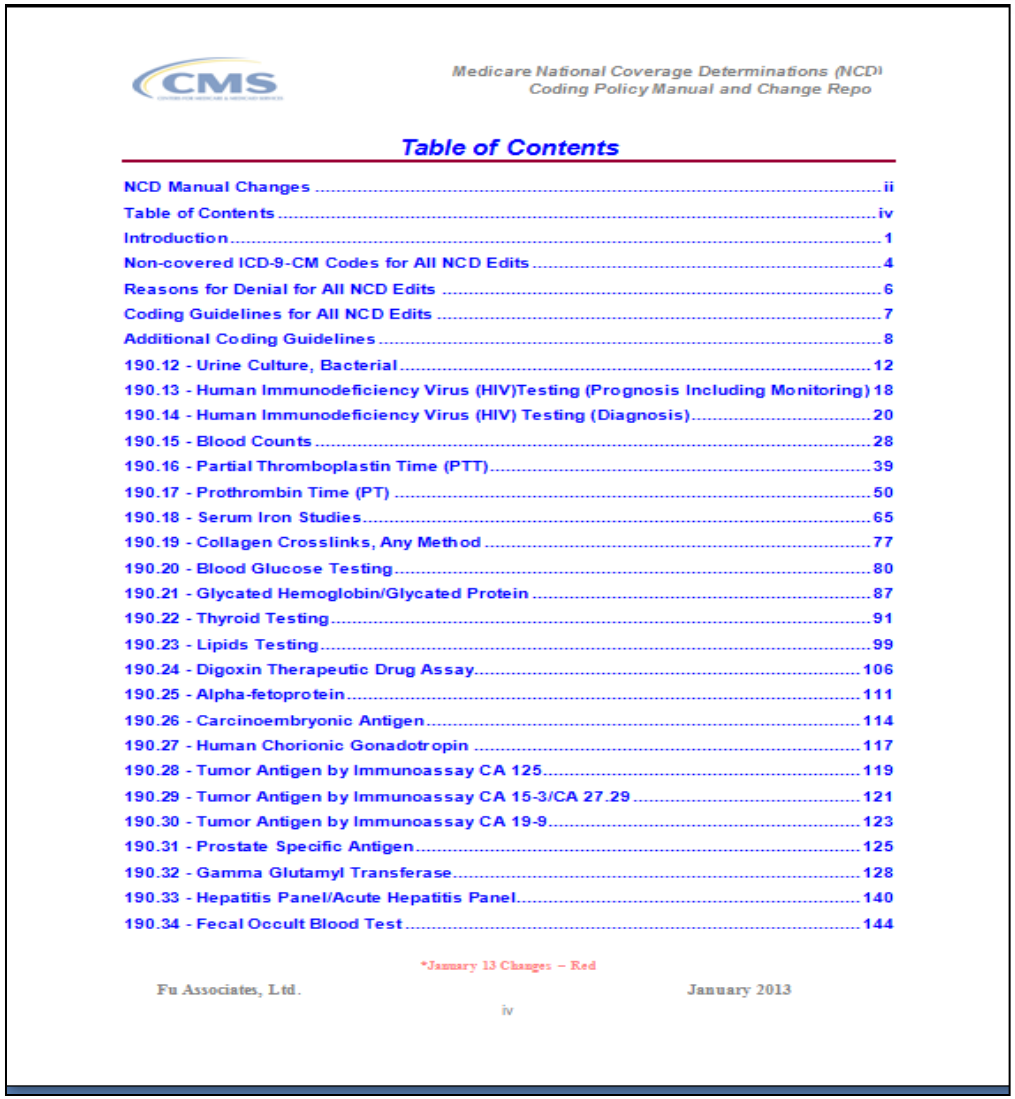
Medicare Coverage - General Information
Compendia 1861 (t)(2) - Anti-cancer
Lab NCDs
Erythropoietin Stimulating Agents Policies
ICD-10
Medicare Coverage - General Information
Medicare provides coverage for items and services for over 43 million beneficiaries. The vast majority of coverage is provided on a local level and developed by clinicians at the contractors that pay Medicare claims. However, in certain cases, Medicare deems it appropriate to develop a National Coverage Determination (NCD) for an item or service to be applied on a national basis for all Medicare beneficiaries meeting the criteria for coverage. This page provides general information on various parts of that NCD process, resources of both a general and historical nature, and summaries and support documents concerning several miscellaneous NCDs.
People with Medicare, family members, and caregivers should visit Medicare.gov, the Official U.S. Government Site for People with Medicare, for the latest information on Medicare enrollment, benefits, and other helpful tools.
Related Links
Medicare Coverage Database
Medicare Coverage Center
Medicare Coverage Determination Process
Page last Modified: 04/03/2014 8:03 AM
Help with File Formats and Plug-Ins

http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report January 2013
Clinical Diagnostic Laboratory Services
Health & Human Services Department
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
CMS Email Point of Contact:
CAG_Lab_NCD@cms.hhs.gov
TDD 410.786.0727
Fu Associates, Ltd.

Table of Contents



Medicare National Coverage Determinations (NCD)
Coding Policy Manual and Change Repo

Table of Contents

NCD Manual Changes ii
Table of Contents iv
Introduction 1
Non-covered ICD-9-CM Codes for All NCD Edits 4
Reasons for Denial for All NCD Edits 6
Coding Guidelines for All NCD Edits 7
Additional Coding Guidelines 8
190.12 - Urine Culture, Bacterial 12
190.13 - Human Immunodeficiency Virus (HIV)Testing (Prognosis Including Monitoring) 18
190.14 - Human Immunodeficiency Virus (HIV) Testing (Diagnosis) 20
190.15 - Blood Counts 28
190.16 - Partial Thromboplastin Time (PTT) 39
190.17 - Prothrombin Time (PT) 50
190.18 - Serum Iron Studies 65
190.19 - Collagen Crosslinks, Any Method 77
190.20 - Blood Glucose Testing 80
190.21 - Glycated Hemoglobin/Glycated Protein 87
190.22 - Thyroid Testing 91
190.23 - Lipids Testing 99
190.24 - Digoxin Therapeutic Drug Assay 106
190.25 - Alpha-fetoprotein 111
190.26 - Carcinoembryonic Antigen 114
190.27 - Human Chorionic Gonadotropin 117
190.28 - Tumor Antigen by Immunoassay CA 125 119
190.29 - Tumor Antigen by Immunoassay CA 15-3/CA 27.29 121
190.30 - Tumor Antigen by Immunoassay CA 19-9 123
190.31 - Prostate Specific Antigen 125
190.32 - Gamma Glutamyl Transferase 128
190.33 - Hepatitis Panel/Acute Hepatitis Panel 140
190.34 - Fecal Occult Blood Test 144

*January 13 Changes – Red

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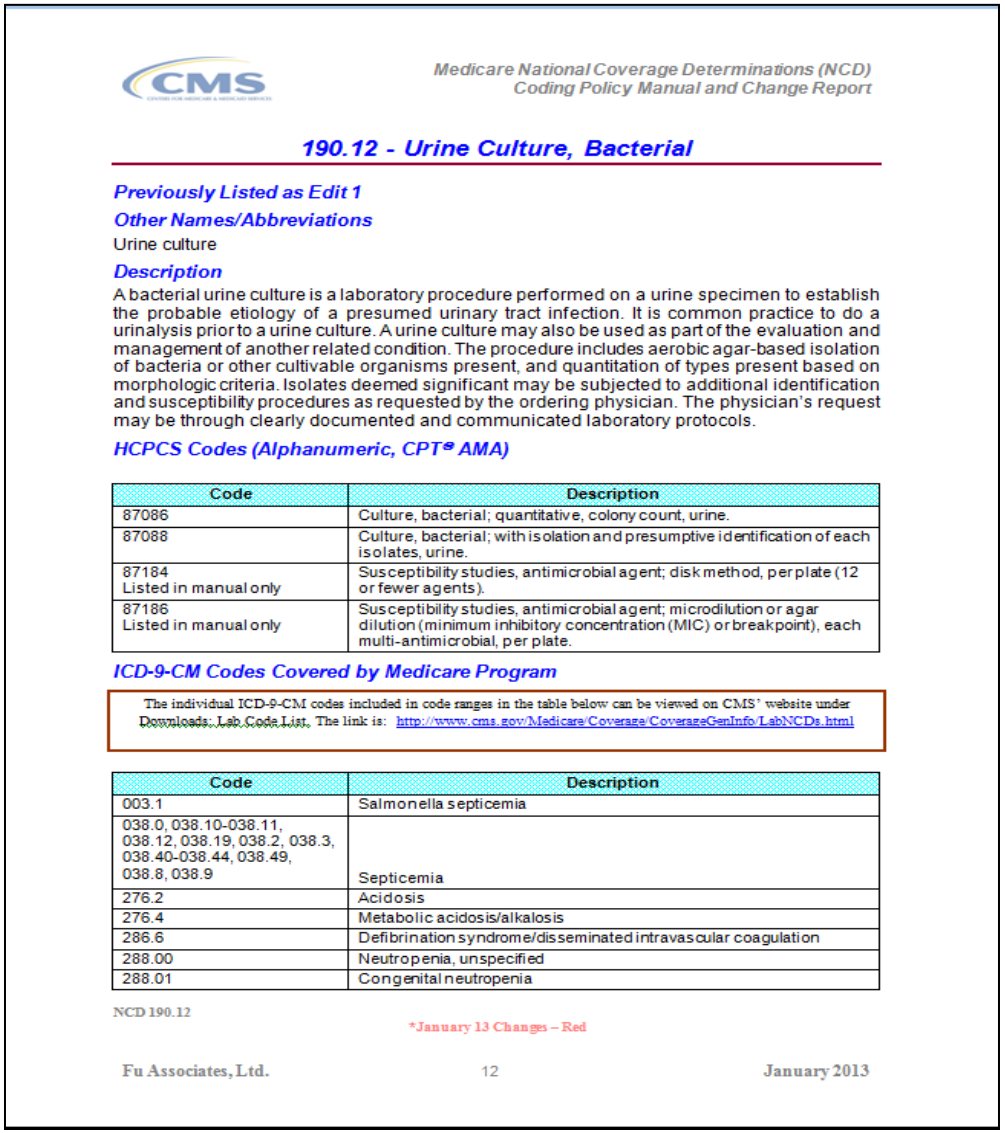
iv

Specific NCD Information

- Description
- CPT/HCPCS codes
- ICD-9 CM codes covered



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Medicare National Coverage Determinations (NCD)
Coding Policy Manual and Change Report

190.12 - Urine Culture, Bacterial

Previously Listed as Edit 1

Other Names/Abbreviations

Urine culture

Description

A bacterial urine culture is a laboratory procedure performed on a urine specimen to establish the probable etiology of a presumed urinary tract infection. It is common practice to do a urinalysis prior to a urine culture. A urine culture may also be used as part of the evaluation and management of another related condition. The procedure includes aerobic agar-based isolation of bacteria or other cultivable organisms present, and quantitation of types present based on morphologic criteria. Isolates deemed significant may be subjected to additional identification and susceptibility procedures as requested by the ordering physician. The physician's request may be through clearly documented and communicated laboratory protocols.

HCPCS Codes (Alphanumeric, CPT® AMA)

Code	Description
87086	Culture, bacterial; quantitative, colony count, urine.
87088	Culture, bacterial; with isolation and presumptive identification of each isolates, urine.
87184 Listed in manual only	Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents).
87186 Listed in manual only	Susceptibility studies, antimicrobial agent; microdilution or agar dilution (minimum inhibitory concentration (MIC) or breakpoint), each multi-antimicrobial, per plate.

ICD-9-CM Codes Covered by Medicare Program

The individual ICD-9-CM codes included in code ranges in the table below can be viewed on CMS' website under Downloads: Lab Code List. The link is: http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html

Code	Description
003.1	Salmonella septicemia
038.0, 038.10-038.11, 038.12, 038.19, 038.2, 038.3, 038.40-038.44, 038.49, 038.8, 038.9	Septicemia
276.2	Acidosis
276.4	Metabolic acidosis/alkalosis
286.6	Defibrination syndrome/disseminated intravascular coagulation
288.00	Neutropenia, unspecified
288.01	Congenital neutropenia

NCD 190.12

*January 13 Changes – Red

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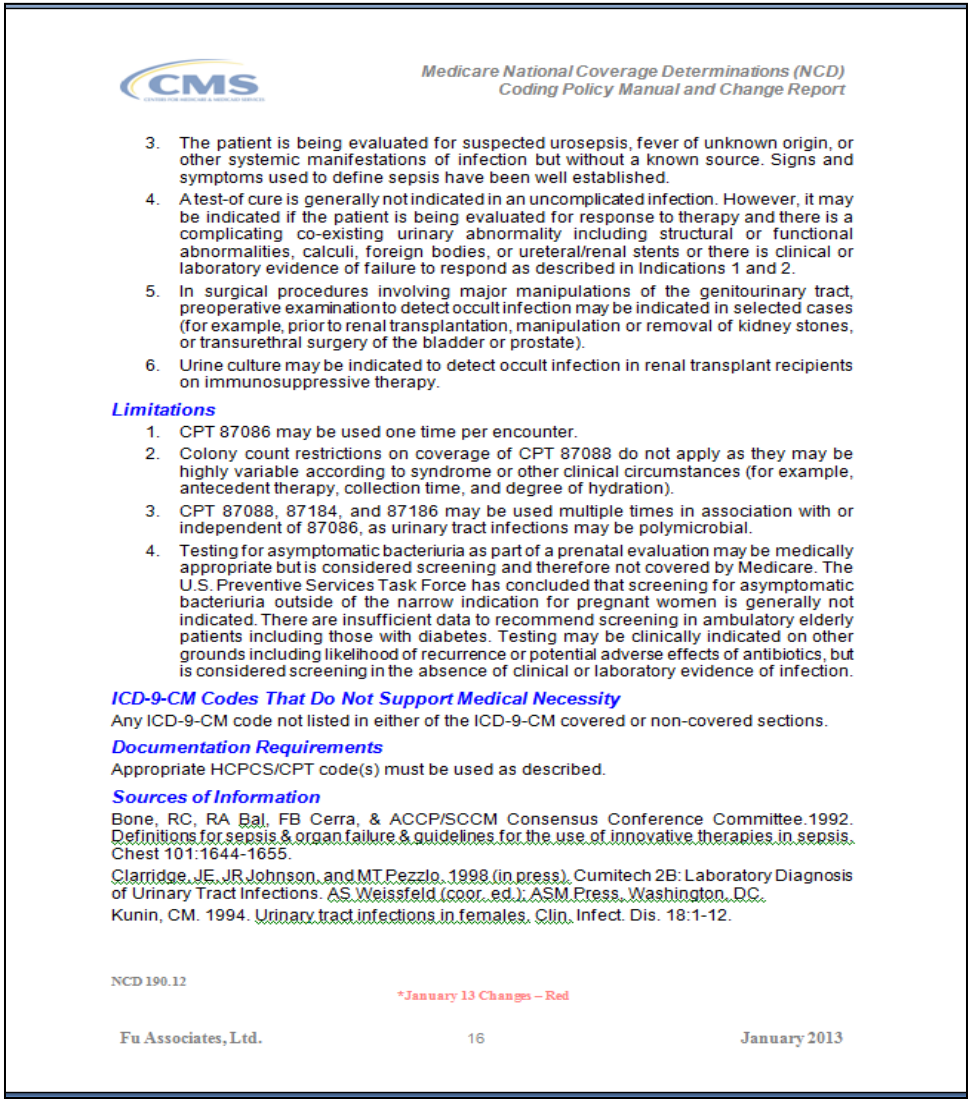
Specific NCD Information

- Indications
- Limitations
- Documentation



3. The patient is being evaluated for suspected urosepsis, fever of unknown origin, or other systemic manifestations of infection but without a known source. Signs and symptoms used to define sepsis have been well established.
4. A test-of cure is generally not indicated in an uncomplicated infection. However, it may be indicated if the patient is being evaluated for response to therapy and there is a complicating co-existing urinary abnormality including structural or functional abnormalities, calculi, foreign bodies, or ureteral/renal stents or there is clinical or laboratory evidence of failure to respond as described in Indications 1 and 2.
5. In surgical procedures involving major manipulations of the genitourinary tract, preoperative examination to detect occult infection may be indicated in selected cases (for example, prior to renal transplantation, manipulation or removal of kidney stones, or transurethral surgery of the bladder or prostate).
6. Urine culture may be indicated to detect occult infection in renal transplant recipients on immunosuppressive therapy.

Limitations

1. CPT 87086 may be used one time per encounter.
2. Colony count restrictions on coverage of CPT 87088 do not apply as they may be highly variable according to syndrome or other clinical circumstances (for example, antecedent therapy, collection time, and degree of hydration).
3. CPT 87088, 87184, and 87186 may be used multiple times in association with or independent of 87086, as urinary tract infections may be polymicrobial.
4. Testing for asymptomatic bacteriuria as part of a prenatal evaluation may be medically appropriate but is considered screening and therefore not covered by Medicare. The U.S. Preventive Services Task Force has concluded that screening for asymptomatic bacteriuria outside of the narrow indication for pregnant women is generally not indicated. There are insufficient data to recommend screening in ambulatory elderly patients including those with diabetes. Testing may be clinically indicated on other grounds including likelihood of recurrence or potential adverse effects of antibiotics, but is considered screening in the absence of clinical or laboratory evidence of infection.

ICD-9-CM Codes That Do Not Support Medical Necessity

Any ICD-9-CM code not listed in either of the ICD-9-CM covered or non-covered sections.

Documentation Requirements

Appropriate HCPCS/CPT code(s) must be used as described.

Sources of Information

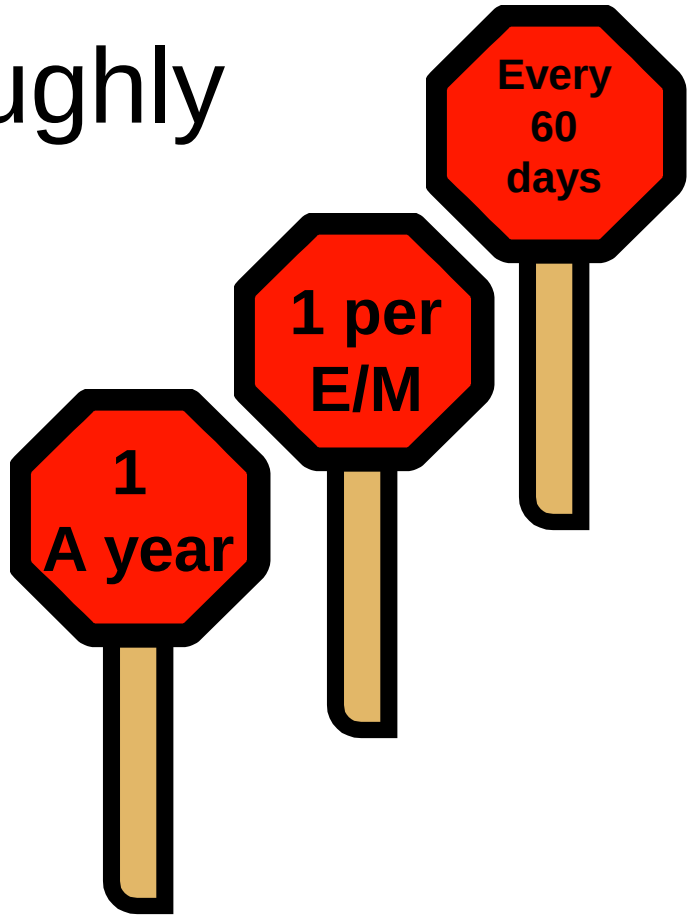
Bone, RC, RA Bal, FB Cerra, & ACCP/SCCM Consensus Conference Committee.1992. Definitions for sepsis & organ failure & guidelines for the use of innovative therapies in sepsis. Chest 101:1644-1655.

Clarridge, JE, JR Johnson, and MT Pezzlo. 1998 (in press). Cumitech 2B: Laboratory Diagnosis of Urinary Tract Infections. AS Weissfeld (coor. ed.): ASM Press, Washington, DC.

Kunin, CM. 1994. Urinary tract infections in females. Clin. Infect. Dis. 18:1-12.

Frequency/Utilization

- Read policy thoroughly
- Check
  - Limitations
  - Utilizations



Covered Preventive Services and the ABN

- Frequency parameters apply
- Become familiar with coverage
- Communicate with patient
- Get required and/or voluntary signed ABNs

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Specialty Specific Requirements

ABN Modifiers

- GA - Waiver of liability statement issued as required by payer policy

- GZ – Item or service expected to be denied as not reasonable and necessary

ABN Modifiers

- GX – Notice of liability issued, voluntary under payer policy

- GY – Item or service statutorily excluded, does not meet the definition of any Medicare benefit

Laboratory Services

- Specimen at lab
  - Lab reviews LCD/NCD
  - Get ABN if necessary

- Specimen sent from office
  - Office review LCD/NCD
  - Send signed ABN to lab

Lab Tips

- Medicare may not pay this Prostate Specific Antigen (PSA) screening lab test; performed less than one year ago
- Screening pays once per year; more frequently, need ABN (unless diagnostic)
- Physicians - forward ABN copy to labs

Podiatry Examples

- Modifier GA (ABN on file)
  - LCD requirements for diagnosis not met
- Modifier GY (no ABN needed)
  - Routine foot care
    - No requirements for coverage

Therapy Example

- Mandatory ABN that exceed cap and not exception
- Modifier GA (ABN on file)
  - The cap has not been met and continuation of service doesn't meet the need for a skilled therapist.
- Modifier GY (no ABN needed)
  - The cap has been met and continuation of service doesn't meet the need for a skilled therapist.

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Resources

Resource Links

- CMS – ABN Form and instructions https://www.cms.gov/BNI/Downloads/ABNFormInstructions.zip
- ABN FAQ – Forms
  - JE - https://med.noridianmedicare.com/web/jeb/forms
  - JF - https://www.noridianmedicare.com/partb/forms/
- CR 6563 - Effective 4/1/2010
- CR 7821-Effective 9/24/2012
- Medicare Learning Network (MLN)
  - http://www.cms.gov/MLNProducts/downloads/MLNCatalog.pdf

CMS References

- ABN
  - www.cms.hhs.gov/bni

- LCDs http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

CMS References

- NCDs
  - http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd

- NCDs – Lab
  - http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html

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Signature Requirements

Signature Purpose

- Clearly identified in the medical records
- Must be legible with first and last name and credentials
- Demonstrate services are documented, reviewed and authenticated
- Certifies the medical necessity and reasonableness of the service

Validity of Signature

- Handwritten signature
  - Must be legible
- Electronic signature
  - Digitized
    - Electronic image of handwritten signature
  - Electronic
    - Statement “electronically signed by” or “verified/reviewed by” followed by practitioner’s name and credentials
  - Digital
    - Electronic method of handwritten signature generated by special encrypted software

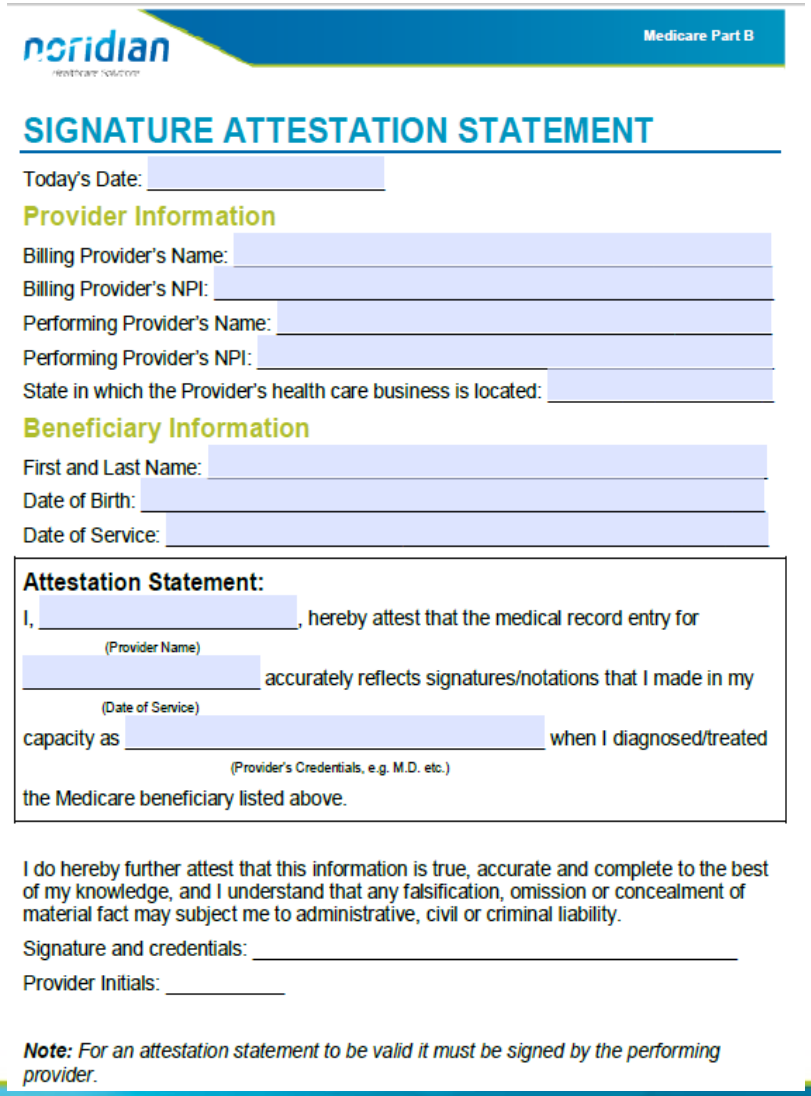
Unacceptable Signature

- Signature stamps
- Records dictated and transcribed without valid signature
- Practitioners name typed on report or records
- Signature on file
- Illegible unrecognizable handwritten signature

Signature not Readable?

- Have an official signature page with name and signature
- Send an attestation statement
  - Certify physician's signature

Signature Attestation



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Medicare Part B

SIGNATURE ATTESTATION STATEMENT

Today's Date: _____

Provider Information

Billing Provider's Name: _____

Billing Provider's NPI: _____

Performing Provider's Name: _____

Performing Provider's NPI: _____

State in which the Provider's health care business is located: _____

Beneficiary Information

First and Last Name: _____

Date of Birth: _____

Date of Service: _____

Attestation Statement:

I, _____, hereby attest that the medical record entry for
(Provider Name)

_____ accurately reflects signatures/notations that I made in my
(Date of Service)

capacity as _____ when I diagnosed/treated
(Provider's Credentials, e.g. M.D. etc.)

the Medicare beneficiary listed above.

I do hereby further attest that this information is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature and credentials: _____

Provider Initials: _____

Note: *For an attestation statement to be valid it must be signed by the performing provider.*

- Electronic signatures
  - Need statement "electronically signed by" or "verified/reviewed by" followed by provider name/credentials
  - Authentication of signing provider must be clearly defined in the records
- IOM Medicare Program Integrity Manual, Publication 100-08, Chapter 3, Section 3.4.1.1
- Signature Fact Sheet
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf CMS "Complying with Medicare Signature Requirements" fact sheet at
- CR6698 Signature Requirements

Signature Check List

Orders

- Legible provider name, date and credentials
- Intent established in signed charts

Plans of Care

- Legible provider name, date and credentials
- Therapist and overseeing provider

Chart notes

- Legible provider name, date and credentials
- Incident to services - both providers of care noted in documentation

Signature Requirements

- Paper requisitions must be signed by rendering/ordering physician/NPP:
  - Clearly identified in records
  - Clinical diagnostic laboratory tests
  - Paid under the Clinical Lab Fee Schedule (CLFS)
- Signature not required when physicians or NPPs request tests using:
  - Annotated medical records
  - Documented telephonic requests
  - Electronically ordered requests
  - Request types not considered requisitions

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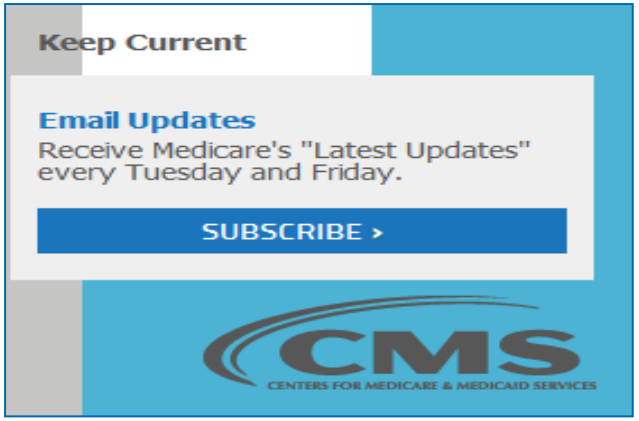
Reminders

Sign Up For Medicare News!

- Receive most recent Noridian/CMS news
  - Regulation/policy updates
  - Payment/reimbursement
  - Workshop/educational event notices
  - Noridian hours of availability/related notifications

JF

JE



Endeavor – Sign Up Today!

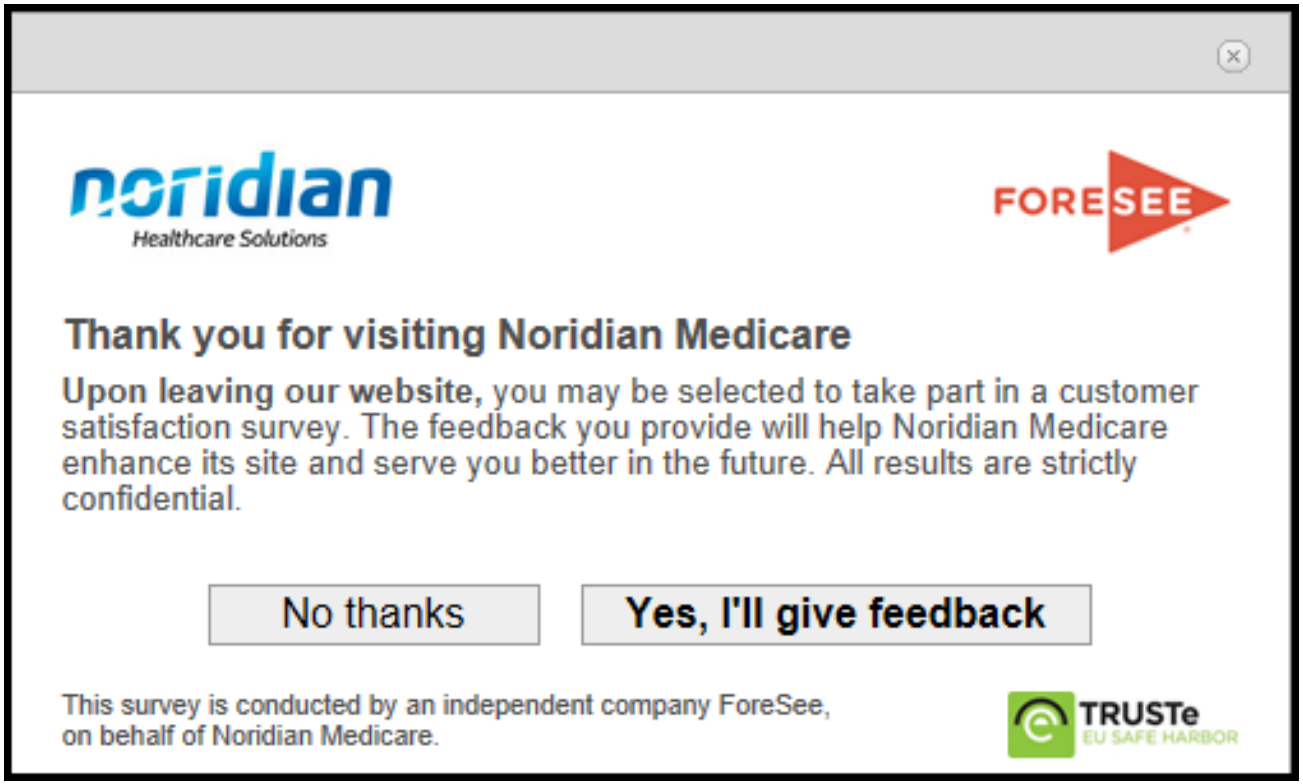
- Free secure internet website
  - Verify Eligibility
  - Check claim and check status
  - View and print Remittance Advice
    - Full or single-claim
  - Reopening/Redetermination requests
    - Submit, view and track

Endeavor – Sign Up Today 2

- EDI registration required
- Hours of operation nearly 24/7
  - Exception for maintenance/CMS required downtime
- Information, tutorials and user manual
- JE
  - https://med.noridianmedicare.com/web/jeb/topics/endeavor;jsessionid=47398DB81B877707CD2B21A1D2314C38
- JF
  - https://www.noridianmedicare.com/partb/claims/endeavor/index.php

Noridian Appreciates Feedback!

- Please complete Foresee Results Website Survey
- Provide constructive/complimentary feedback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Webinar Workshops

Date	Time (CT)	Workshop Title
5/27/14	1:00 PM	Laboratory Services and CERT Documentation
5/29/14	1:00 PM	CCI and MUE Explanation
6/24/14	1:00 PM	Modifiers
6/25/14	1:00 PM	Transitional Care Management
7/16/14	1:00 PM	ACT – Ask the Contractor Teleconference

Watch for May, June and July Webinar and workshop postings!

Register Now!

JE: https://med.noridianmedicare.com/web/jeb/education/training-events

JF: https://www.noridianmedicare.com/partb/train/workshops/index.html

Reminder CEU Process

- Attend entire workshop
- For AAPC credit, add additional names when registering
- Must take short polling survey
  - **After** closing out of workshop
- CEU certificate emailed after workshop
    - No password needed
    - All providers may use CEU certificate
      - Certificate of Attendance no longer available

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Questions

Thank you